BUT WILL THEY COME BACK TO US? DISCHARGING SAFELY FROM SPECIALIST PALLIATIVE CARE

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KEYWORDS

Safe discharge, equity of access to specialist palliative care

EXECUTIVE SUMMARY

The MLHD Specialist Palliative Care Team recognised inconsistencies in clinical care provide to patients deemed to the in the Stable Phase ((PCOC). Current estimates on future demand for palliative care highlight the need to develop a consistent equity-based approach to manage and discharge this patient cohort.

A multi-faceted and quality driven approach was applied to this issue, utilising the available evidence, surveying current district practice, researching discharge procedures in other localities and consulting key stakeholders underpinned clinical practice standardisation.

Developing a procedure, standardising care and discharge for patients deemed stable ensures that stable patients receive quality care and safe discharge.

INTRODUCTION

The MLHD Specialist Palliative Care Team has grown rapidly over a relatively short period of time and undergone a re-structure into a district wide model of care for service delivery. As a consequence of this growth, patient numbers grew and a series of clinical incidents drove practice change to regularly review and discharge patients deemed stable (utilising PCOC). Recognition of variance in discharge practices was a catalyst for undertaking a Quality Improvement project. As a result of this project a much larger body of work has been undertaken to review the delivery of specialist palliative care to patients deemed stable. Care has been streamlined to ensure best practice care and consistent advice, a goal orientated timeline for care is adhered to, ensuring stable patients are discharged in a safe, supported manner. An MDT discharge meeting provides oversight that key clinical interventions are achieved, enabling a smooth transition back to specialist palliative care if required.

HIGHLIGHTS

- Standardised stable palliative care patients discharge enables equity
- Application of multidisciplinary approach to discharge
- Role of allied health input for stable palliative care patients recognised
- District procedure development in alignment with evidence base
- Higher satisfaction for clinicians that discharges are safe

PROCESS

Clinical variance across the MLHD specialist palliative care team was recognised. A request for documentation provided to patients, carers and refers on discharge revealed an adhoc approach of support provided, timing of discharge and pathways back to the service when clinically indicated that impacted on the core tenet of equity of service delivery for the LHD wide model of care.

A survey to all clinicians asked for responses that dictated time frames for discharging stable patients and time frames for direct readmission to the service or whether patients/referrer are guided back to the centralised intake process. From the results a flow chart for discharging stable patients was developed, a standardised discharge letter for referrers created and patient information leaflets under development to supersede a standardised patient discharge information letter.

The survey also revealed the inconsistency of language and timing around discussing and planning discharge of stable patients and led to a broader strategy to expand the quality improvement idea into a catalyst for broad clinical practice change for the whole team.

A literature review was conducted and a case for change written for incorporating a standardised approach for discharging stable palliative care patients based on an evidence-based approach. A scan of current discharge practices across NSW was attended and elements of those incorporated into MLHD procedure development.

The survey and subsequent team discussions revealed clinician fear about discharging patients who may not return to the service and as a result, experiencing poor care outcomes. In tandem with procedure development is educating clinicians on timing to commence discharge planning and scripts for clinicians to communicate around discharge provided. It was also recognised that discharge sat with nursing clinicians only, contrary to evidence that allied health in put is key to the success of early intervention for palliative care patients and key to safe discharge.

External stakeholders' involvement was identified as crucial to enable consistent messaging about referring back to specialist palliative care when clinically indicated. Working collegially with PHN to incorporate common language across their palliative care pathways and collaboratively with community nursing and aged care has been essential to the success of discharging stable palliative care patients.

RESULTS/ OUTCOMES

District wide procedure for Discharge of Stable Palliative Care patients has been developed as an overarching guide. A flow chart clearly steps out the timeline and clinical goals (such as advance care planning, disease/palliative care patient/carer education and carer support). Prior to discharge all stable patients are discussed at the newly formed Palliative Care Discharge meeting.

Ongoing data collection will capture ongoing success of discharging stable palliative care patients,

CONCLUSION

Standardised process for Discharge of Stable Palliative Care patients has been established. Patients and carers now received standardised information on how to return to the service and are provided information and support for Advance Care planning, their disease, care needs and services available to assist them prior to discharge. During the discharge process patients and carers are enabled to return to specialist palliative care seamlessly when they require it and are primed to make their goals of care to align with their personal life goals.

MLHD specialist palliative care clinicians have expressed satisfaction that a standardised, supported quality process for stable patient discharge has been developed.

As a service MLHD may use this model of care as a foundation to integrate Early Intervention/Stable patient Palliative Care clinics into their service as an intervention to manage the predicted demand on the service into the future.